PD-ABM-232
97470

Healthcom II
(Communication for Child Survival)
Final Evaluation

Project Number 936-5984

Prepared by:

Douglas W. Wear
Sandra L. Huffman

Prepared for:

Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

June 1995

The Final Evaluation of the Communication for Child Survival (Healthcom II) Project
was conducted under the auspices of the Office of Health and Nutrition,
Center for Population, Health and Nutrition,
Bureau for Global Programs, Field Support and Research,
United States Agency for International Development.
The Evaluation was conducted by the Health Technical Services Project of TvT Associates Inc.
and The Pragma Corporation, Contract Number HRN-5974-C-00-3001-00. The opinions
expressed herein are those of the authors and do not necessarily reflect the views of TvT, Pragma
or the U.S. Agency for International Development.

Additional copies of this report may be obtained in writing to:

The Health Technical Services Project
1601 N. Kent Street, Suite 1104
Arlington, VA 22209
(703) 516-9166
(703) 516-9188 (fax)

Preface

This final evaluation of the Communication for Child Survival (Healthcom II) Project (Project No. 936-5984) was carried out at the request of the USAID Office of Health and Nutrition. The evaluation was conducted during the period April 5 through June 30, 1995 in Washington, D.C. by two professionals with combined expertise in team leadership, contract management and administration, social marketing, applied research, evaluation, and policy.

Evaluation Team Members	Team Position
Mr. Douglas Wear Senior Consultant	Team Leader Social Marketing Expert
Dr. Sandra Huffman Senior Consultant Former President, NURTURE/Center to Prevent Childhood Malnutrition	Health and Nutrition Applied Research and Policy Expert

Acronyms

ACT	Applied Communication Technology
AED	Academy for Educational Development
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival Project
CDD	Control of Diarrheal Disease
CIESPAL	International Center for Advanced Studies in Communication for Latin America
CS	Child Survival
CTO	Cognizant Technical Officer
DOH	Department of Health
EPI	Expanded Program of Immunization
FNU	Fatayat Nadhaltul Ulama = Islamic Women's Volunteer Organization, Indonesia
HC-I	Healthcom I Project
HEALTHCOM	Communication for Child Survival Project
HKI	Helen Keller International
IEC	Information, Education and Communication
INCAP	The Nutrition Institute for Central America and Panama
JHU	The Johns Hopkins University
KAP	Knowledge, Attitudes, and Practices
MCH	Maternal and Child Health
MOH	Ministry of Health
MMHP	Mass Media and Health Practices Project
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
OYB	Operational Year Budget
PATH	Program for Appropriate Technologies in Health
PAHO	Pan American Health Organization
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
PRITECH	Technologies for Primary Health Care Project
REACH	Resources for Child Health Project
ROVITA	Oral Rehydration and Vitamin A Project (pilot project in Central Java)
SEAMEO	Southeast Asian Ministers of Education Organization
SOMARC	Social Marketing for Change Program
SOMAVITA	Social Marketing of Vitamin A Project (national program, Indonesia)
TA	Technical Assistance
TAG	Technical Advisory Group
USAID	U.S. Agency for International Development

Table of Contents

Preface I
Acronyms ii
Table of Contents iii
Executive Summary v

I. Introduction 1
- A. Purpose 1
- B. Project Summary 1
- C. Methods 2

II. Contract Performance 5
- A. Activities (Deliverables) 5
- B. Management and Financial Tracking 6
- C. Amendments to the Contract 10

III. Contract Management 11
- A. Staffing 11
- B. Relationships with USAID/W and USAID's Technical Direction 12
- C. Relationships with USAID Field Missions 12

IV. Contract Achievements 15
- A. The Health Communication Methodology 15
- B. Adapting the Methodology to New Areas 15
- C. Publishing and Disseminating the Methodology and Results of Healthcom II 17
- D. Lessons Learned in Behavior Change 19
  - 1. Hard-to-Reach 20
  - 2. Preventive vs. Treatment Behaviors 20
  - 3. Mixing of Strategies 21
  - 4. Applied Research: Findings in Behavior Change and Maintenance . 21
- E. Role of Evaluations 24
  - 1. Evaluations of Healthcom I Programs 24
  - 2. Healthcom II Evaluations 25
  - 3. Cost-Effectiveness Analyses 29
- F. Role of Training 30
- G. Institutionalization and Sustainability 31
  - 1. Project Goals 31
  - 2. Lessons Learned in Institutionalization and Sustainability 36

V. Conclusions and Recommendations 37

TABLES

1a-e. Project Activities Specified and Implemented 5-9
2. Interventions Promoted by Healthcom II in Long-term Countries 16
3a. Evaluations Conducted in Healthcom I 26
3b. Evaluations Conducted in Healthcom II 28
4. Strategies Used in Healthcom II Countries to Institutionalize Activities in Long-term Countries 32

APPENDICES

Annex A List of Individuals Contacted
Annex B Materials Reviewed
Annex C Healthcom II Final Evaluation Scope of Work
Annex D Issue Papers and Papers Published in Scientific Journals
Annex E Description of Healthcom II Materials
Annex F List of Healthcom Materials for Distribution by BASICS

Executive Summary

I. BACKGROUND

The Communication for Child Survival Projects (Healthcom I and II) and the predecessor project, Mass Media and Health Practices (MMHP) represent a series of health communication program activities funded by USAID that span almost a two-decade period of time (1978-1995). All three projects have been implemented by the Academy for Educational Development (AED). The Healthcom II project is the subject of this final evaluation (1989-1995). It is noteworthy that certain aspects of Healthcom II are presently included in the BASICS (Basic Support for Institutionalizing Child Survival) Project.

This evaluation considers the areas of contract performance, management, achievements and lessons learned in institutionalization and sustainability. The evaluation was guided by a series of questions provided in a scope of work by the USAID Office of Health and Nutrition (Annex C).

II. FINDINGS

With regard to Healthcom II performance, AED complied with the deliverables specified in their amended contract (see page 10 for a discussion of contract amendments), and in only some cases, exceeded the original contract's requirements. In meeting its contractual obligations, the contractor ensured a program output that has received overall high praise.

As noted in this report, some difficulties did exist in the areas of: 1) contract management, including the area of funding (a major reduction in expected levels of funding during the first year- and one-half of the project); 2) relationships between the contractor and USAID; and 3) USAID's technical direction. It was difficult, however, to find that the final output of the amended contract was affected in any substantive way by these particular circumstances.

During Healthcom II a five-step communication methodology to promote behavior change—1. Assess, 2. Plan, 3. Pretest, 4. Deliver, and 5. Monitor—was used in 13 different child survival and health areas, in some 26 countries. In addition to its work in countries, Healthcom II used a number of different channels for dissemination of the methodology and the results of its activities. These included manuals, a published book, issue papers, videos, slides and associated guides, curricula, scientific publications, training modules, and presentations at workshops. (A detailed description of these appear in Annex E.)

Among others, two of the major purposes and expected outcomes of the Healthcom II contract were:

> ". . . generation of evaluative information . . ." including cost-effectiveness analyses.
>
> "Institutionalizing effective communication capability in appropriate public and/or private host country organizations."

There were some weaknesses in the area of evaluation of Healthcom II programs and cost-effectiveness analyses of implemented programs (see Section E.1., 2., 3.).

Regarding institutionalization, it is a difficult goal to accomplish and an even harder one to measure, and the contractor could have done a better job of clearly assessing and documenting this issue. Moreover, it is unclear whether the achievements reached from efforts initiated by Healthcom II will continue in the targeted countries without some level of external funding.

The contract required the contractor to establish criteria to measure institutionalization and sustainability at project start-up. This was never accomplished as originally intended, although general indicators of institutionalization were developed early in the project. Many of Healthcom II's country activities can be classified under these indicators. Project activities described below demonstrate either progress toward institutionalization or some degree of institutionalization.

- Work with a wide range of international, regional, and national groups, such as WHO, PAHO, and INCAP, who have incorporated the methodology into their on-going work and who have bestowed upon Healthcom II high praise for the quality and technical merit of their work.

- Revision of policies and norms within Ministries of Health (e.g., in Peru and Ecuador, national communication policies were adapted based on the work of Healthcom; and in Indonesia, the Department of Health allowed Vitamin A capsules to be distributed outside of the regular health post system, representing a major policy change).

- Numerous training workshops held for MOH, NGO, and other private sector staff including universities.

- Functioning public-private sector partnerships and participation of the private sector in the promotion and distribution of communication messages as well as supplies and materials (e.g., collaboration with Colgate-Palmolive in Ecuador).

- Technical assistance on revision of curricula, such as within schools of public health.

- Bilateral and international agencies (UNICEF, World Bank, WHO, FAO), child survival, and other health intervention projects now include health communication as a major strategy and/or component of their work. (While Healthcom II cannot take sole credit for the adoption of the methodology by these agencies, its efforts and contributions have certainly played a significant role.)

This is the legacy of almost 20 years of support by USAID in the field of communication for behavior change that has included Healthcom II. Health communication is now accepted as a critical component of any public health intervention.

As one of the individuals involved in the project said, quite accurately,

> "The world is different now in terms of development communications. Healthcom has increased the legitimacy of the concept of communication for behavior change. They have increased its use in different areas, i.e., with AIDS, and including domestic communication, a major spin-off that was not conceived of in the original design of the project."

III. RECOMMENDATIONS

Based upon the investigation and findings of this evaluation, the following recommendations are suggested relative to certain follow-on activities as well as future work in the area of health communication:

1. **While some institutionalization did take place due to the Healthcom II contract, the issue was never clearly assessed.**

   Future projects should consider assigning one individual to track the overriding issues of institutionalization and sustainability and make recommendations to the project on means to achieve sustainability. Their role would be to ensure that programs do get evaluated and activities institutionalized (to the extent possible). In order to effectively accomplish this, a set of clear and realistic goals and criteria, having specific objectives and outputs, need to be established for "institutionalization." These criteria, goals, and outputs should be included within the project's contract.

2. **Institutionalization is a continuing process, not a goal that can be achieved in a limited time span.**

   A repeated theme during interviews for this evaluation was that the actual time frame for implementing an in-country program (during a five-year contract), is one- and one-half to two-years in length, due to the approval and contracting process, fielding resident advisors, and leaving time to evaluate and close down program activities. This is not a long enough time period to establish any degree of institutionalization.

   USAID needs to consider this in the design of future communication programs. Arranging to continue the project through counterpart activities after the central project has ended is one possibility.

3. **USAID should attempt to have no more than two CTOs manage a project over its five-year lifetime.**

   While it may be unrealistic to expect that CTOs can provide the majority of their time to a single project given the shortage of staff at USAID, the CTO should not be subject to a workload that makes it difficult to provide support to the project when required.

4. **Healthcom demonstrated some success in mobilizing groups (such as UNICEF, WHO, PAHO, local NGOs, etc.) to common ends using the communication methodology.**

   Future programs should ensure that this effort continues.

5. **A future program should attempt to develop regional approaches.**

   This has been done with some success by SOMARC, the Social Marketing for Change Program (a contraceptive social marketing activity). A number of interventions lend themselves to a regional approach, such as AIDS and cholera.

6. **Because of the inherent problems in funding with MOHs, it would be useful for a future project to consider ways to institutionalize the health communication methodology within the private sector. Concurrently, future projects should consider ways to convince policy makers and donors that preventing illness is cheaper and more cost effective than treating illness.**

   This would provide an incentive for MOHs to commit more of their limited budgets to health communication.

7. **Cost-effectiveness studies should be included in future activities, and guidelines prepared on how to project expenditures for health communication activities.**

8. **Future projects should focus on how to maintain behavior changes, as well as on how to obtain changes in multiple behaviors related to different outcomes, such as improving feeding, weaning food storage, and hand washing.**

9. **In future activities, it would be useful to build in evaluation criteria from the start.**

   Such criteria could include follow-up of previously trained staff to track what they are doing several years after training and whether they continued to use the IEC methods, even though they may have left previous jobs. It *could also include assessing whether curricula or modules that had been jointly developed were used subsequent to the original activities. For example, modules that were developed for workshops with CIESPAL in Latin America and SEAMEO in Asia. Were they used after the original workshops?*

   An analysis would also be useful concerning why changes in health practices occurred due to the interventions in some countries but not in others, when they used the same methodology.

   Future health communication project reports and evaluations should include information on the size of the target population and the estimated proportion reached by the intervention.

10. **Due to the high costs of writing, printing, and disseminating materials, it would be worthwhile to evaluate the impact that the previous disseminations have had, including an analysis of which materials were most useful.**

    This could be done by taking a sample of people who previously received materials, and surveying them to see how they have used the materials and which materials were most useful. Subsequently, a list could be published of the useful materials produced by Healthcom I and II. BASICS and USAID could then develop plans for marketing and disseminating these materials.

11. **Field test the "Tool Box", revise it, and consider translating it into Spanish and French (and perhaps Arabic and Bahasa Indonesian).**

Introduction

A. PURPOSE

Healthcom II was a $17 million five-year (Sept. 1, 1989-April 30, 1995) contract managed by the Office of Health (now the Office of Health and Nutrition). Healthcom II followed a decade of USAID efforts in health communication, including Mass Media and Health Practices (MMHP), 1978-1984, and Healthcom I, 1985-1990. The Academy for Educational Development (AED) was the prime contractor on all three efforts.

The subcontractors for Healthcom II include:

- Annenberg School for Communications/University of Pennsylvania
- Porter/Novelli
- Applied Communication Technology
- Johns Hopkins University
- Birch and Davis International
- The Futures Group International

The purpose of Healthcom II was to assist USAID "to achieve appropriate and sustainable health behavior by mothers, fathers, and other caretakers through modern communication knowledge and technology in order to reduce infant and early childhood mortality and morbidity in developing countries."

As stated in the contract's scope of work "this was to be accomplished through:

1. Assistance to selected countries to develop and implement effective health communication strategies.

2. Institutionalizing effective communications capability in appropriate public and/or private host country organizations.

3. Continued application and development of the health communication methodology."

B. PROJECT SUMMARY

The first 18 months of Healthcom II overlapped with Healthcom I, and the annual reports for FY 1990 were combined. Healthcom I had total expenditures of $18.1 million for the 5 years (with $6.7 million from mission buy-ins and $1.4 million from regional buy-ins). Healthcom II had total expenditures of approximately $17 million, with approximately $4 million from mission buy-ins and $1 million from other central sources (buy-ins, OYBs).

Healthcom I included projects in 13 long-term countries, while Healthcom II included nine. Much of the first year of Healthcom II was spent completing activities started in Healthcom I, including closing out Healthcom I country activities in several countries, conducting summary evaluations, and completing several manuscripts.

In addition, most of the research agenda for Healthcom II included the analysis of data and the writing of results for cross-country comparisons and for country evaluations of Healthcom I projects. This was accomplished primarily by the Annenberg School for Communications, University of Pennsylvania.

C. METHODS

The USAID Office of Health and Nutrition requested assistance in this evaluation of Healthcom II from the Health Technical Services Project.

The evaluation team included Douglas Wear, Social Marketing Expert and Team Leader, and Sandra Huffman, Health and Nutrition Applied Research and Policy Expert. The evaluation was conducted through interviews with USAID central office staff, USAID mission staff in five countries, Healthcom II staff of the prime and subcontractors, and others familiar with the project (see Annex A for a list of individuals contacted). Documents produced by Healthcom II were reviewed, including the contract, amendments, and delivery orders; annual reports; country reports; issue papers; program evaluations; and other publications (Annex B).

Due to funding limitations and the timing of this evaluation, no country program sites were visited. The authors would like to note that not having the ability to actually visit sites is a significant constraint to fully understanding a project and its outputs. Best efforts were made to understand and evaluate this project through the review of materials, and through interviews (in person and by telephone) with numerous individuals involved in the project.

The evaluation was conducted from April 5 through June 30, 1995.

The USAID Office of Health and Nutrition provided a series of questions to be used to guide the evaluation (Annex C). The areas to be considered included:

- Contract Performance
- Contract Management
- Contract Achievements
- Lessons Learned in Institutionalization and Sustainability

This evaluation was also guided by a list of expected accomplishments and achievements that were stated in the contract between USAID and AED:

> "At the end of the contract's five-year life, the measure of its near-term success will be the presence of a child survival health system that includes such components as, for example:
>
> 1. An appropriately funded and professionally staffed Health Education Unit within the MOH.
> 2. Participation of private producers, suppliers, and other for-profit and voluntary organizations in the promotion and distribution of communication messages as well as supplies and materials.
> 3. Functioning public-private sector partnerships.
> 4. Incorporation of child survival concepts and messages in formal educational curricula and in health professional training—physicians, pharmacists, and others.
> 5. A significantly increased demand for child survival services at the community level.
> 6. A tested HEALTHCOM model that can be quickly and effectively adapted to diverse sociocultural conditions, both in original application and in area-to-area replication."

In addition, the contract stated that indicators of institutionalization and sustainability efforts will include changes in program, policies, planning, staffing, budgets, and others, and that while many of the above-listed outputs will take longer than five years, there should be demonstrated significant progress in each of these areas.

II. Contract Performance

A. ACTIVITIES (DELIVERABLES)

Table 1 (a-e) summarizes the project activities specified in the original contract scope of work and the actual activities implemented in Healthcom II. Several of the initial requirements were changed during the course of the project. (This fact is thoroughly described in Section II.C. Amendments to the Contract.)

Healthcom II conducted numerous short-term technical assistance activities in over 20 countries in addition to its long-term work in nine countries.

The applied research component was implemented primarily by Annenberg, and included the completion of ten Healthcom I evaluations, several inter-country comparisons of particular behavioral issues, and publication of research papers.

The initial contract requested the production of ten to 15 issue reports concerning "key health communication areas based on field experience" and five major articles published in scientific journals. Toward the end of the contract period, the contract was amended to include a minimum of five issue reports, and ten to 15 publications in scientific journals. (For an explanation of the Amendments to the Contract, see page 10.) While AED did not create an issue report series, there were more than 15 reports prepared by the project that discussed "key communication areas." Many of the "issue reports" were published in scientific journals, and others were presented at international workshops, and/or distributed to health practitioners in the field. However, there was no central site (such as a library or resource room) at AED that would allow these to be easily perused.

Several alternate formats were developed by the project to present the methodology. The publication of the book Communication for Health and Behavior Change by Jossey\Bass Publishers, ensured that the methodology was available to a wide audience, and would facilitate its expansion to the academic community at large. The production of the "Tool Box," the "Focus Group Kit," and the "Behavioral Video and Guide" were other innovative means to present the methodology. These are discussed in Section IV.C. Publishing and Disseminating the Methodology and Results of Healthcom II.

As shown in the following tables, AED complied with the deliverables specified in their amended contract, and, in only some cases, exceeded the original contract's requirements.

B. MANAGEMENT AND FINANCIAL TRACKING

Healthcom II's management has satisfactorily met contractual obligations and ensured a program output that has received overall high praise. The program's financial tracking and management in particular have received high compliments from Healthcom's CTOs at USAID. However, there were significant difficulties and delays in receiving obligated funds from USAID during the first year- and one-half of Healthcom II. This caused some reduction in professional and support staff and delay in start-up of some programmatic activities.

Healthcom II staff also reported significant delays in the negotiation of delivery orders, and stated that their CTOs experienced difficulty obtaining accurate financial information from USAID's Office of Financial Management.

TABLE 1a.
Project Activities Specified and Implemented: Technical Assistance

Activity	Required in Scope of Work	Implementation	Sites
Intensive Long-term TA	Six (6) countries that received assistance from Healthcom I; increasing from one to two previous interventions by two more; multiple long-term advisors	Contract revised to include six (6) countries only if missions requested and provided money (contract modification # 18)	Zero (0)
Less-intensive Long-term TA	Nine (9) countries; Up to three (3) CS interventions; One resident advisor	Nine (9) countries	Burkina Faso, Egypt, Honduras (also HC-I), Indonesia (also HC-I), Mali, Peru, Philippines, Senegal, Yemen (also HC-I)
Short-Term TA	No required amount		Bolivia, Caribbean[1], Ecuador, Guatemala, Jamaica, Lesotho, Kenya, Mexico, Morocco, Mozambique, Niger, Nigeria, Panama, Papua New Guinea, Philippines, Surinam, Uganda

[1] Belize, Jamaica, St. Lucia, Barbados, Trinidad

TABLE 1b.
Project Activities Specified and Implemented: Applied Research and Evaluation

Project Activity	Required in Scope of Work	Healthcom II Implementation
Applied Research	Address global methodological issues across countries	Several cross-country comparisons were written
	Refinement of communication methodology for application and adaptation	Development of *Tool Box, Focus Group Kit,* and *Behavior Change* book
	Institutionalization of communication methods	Evaluations of Healthcom I projects included sections on institutionalization
	Sustainability of behavior changes	ACT study in Honduras noted sustained behavior changes in ORT usage after Healthcom I project had ended
	Most of this work should be in long-term sites	
Honduras Evaluation	Collect and analyze data from the communication activities including analysis of long-term behavior change	Amended to not be required

TABLE 1c.
Project Activities Specified and Implemented: Dissemination

Project Activity	Required in Scope of Work	Healthcom II Implementation
Dissemination	Produce second edition of Communication for Child Survival with emphasis on institutionalizing communication and sustaining behavior	Produced Notes from the Field: Communication for Child Survival; three out of 24 chapters on institutionalization/ sustainability; produced *Tool Box* providing methodology to users
	Ten-15 Issue Reports	Amended to five >15 reports completed
	Publish minimum of five major articles in scientific journals	Amended to Ten-15 20 published
	Three regional workshops	Amended to not be required
	One international workshop	Amended to not be required
	Two to four seminars/year	Ten held
	Country level workshops (three/year, two weeks each); Graduate level communication degree program: Two two-year. programs	43 held of two weeks or more
	One to three training sessions in communication methodology of university faculty	Six held
	One to three training sessions for communication advisors	One held
	Explore alternate formats for presenting communication methodology	Published book, *Tool Box, Focus Group Kit, Behavioral Video and Guide*

TABLE 1d.
Project Activities Specified and Implemented: Project Reports and Meetings

Project Activity	Required in Scope of Work	Healthcom II Implementation
Technical Meetings	Five (5) Technical Advisory Groups (TAGS)	Amended to three (3) Three (3) held
	Five Task Forces	Amended to three (3) Three (3) held
	Monthly technical meetings between CTO and AED	Held when CTO available
Evaluation	Each country implementation plan will propose evaluation criteria	
	Overall set of evaluation criteria to be proposed in the initial work plan	Not included in work plan
Reports	Five (5) Annual reports	Five (5) completed
	Final Report	Completed
	Trip Reports	Completed
	Financial Reports	Completed

TABLE 1e.
Project Activities Specified and Implemented: Implementation Plans

Project activity	Required in Scope of Work	Healthcom II Implementation
Implementation Plans	Five (5) for project (one per year)	Completed (Fifth in draft)
	Country strategy plan (including discussion of long-term institutionalization)	Completed
	Country implementation plans	Completed

C. AMENDMENTS TO THE CONTRACT

Due to funding reductions during the first one- and one-half years of the project, several modifications to the contract were made, including amending the total number of TAGs and Task Force meetings required. Reducing the requirements of the contract may have affected some of the project's activities. For example, TAG and Task Force meetings might have helped project staff to put more of an emphasis on institutionalization and evaluation.

These early financial difficulties led to the amendment to delete the proposed follow-up evaluation of the long-standing Honduras program. Due to lack of funding, the subcontractor was not able to initiate this evaluation, and once funding was restored, other work precluded the evaluation taking place. However, the Honduras mission was never consulted and they expressed concern that this follow-on study was not conducted. Since Honduras had been such an important long-term site for Healthcom, this lack of an evaluation was a significant deficit. As discussed later in Section IV.F. The Role of Evaluations, little information is available on the long-term impact of Healthcom activities and Honduras would have been an important site to examine this issue.

Another contract amendment deleted the requirement for intensive long-term technical assistance in six countries with resident advisors. Because these programs were dependent upon mission buy-ins, which were not obtained, there was insufficient funding to meet this goal. The lack of early core funding for the project, with requisite reductions in staff and travel funds, may have inhibited the project's ability to search for these buy-ins. However, Healthcom II staff state that they believe local missions were not interested in having special Healthcom II long-term projects with several long-term advisors, because they had their own large bilateral child survival projects with several advisors with whom they wanted Healthcom II to coordinate.

The deletion of the requirement for intensive long-term technical assistance in turn led to an amendment to delete the international and regional workshops, precisely because there were too few country advisors to warrant these workshops.

Another amendment to the contract related to the number of expected scientific publications and issue papers. This modification was proposed in year three of the project, but not finalized until the final year due to USAID delays in approval. While it appeared at the time of the proposed modification that the expected number of articles would not be published by the contract end date, ultimately the total number of publications actually exceeded the original contract specifications.

The USAID CTO, who agreed to the above amendments, stated that amending the contract is a common practice at USAID. It was further explained that factors outside the contractor's control sometimes inhibit their ability to meet the outputs. Alternatively, when the CTO and contractor no longer believe the provision to be relevant, contract amendments are usually in order.

III. Contract Management

A. STAFFING

Healthcom II staff reported that, in general, the contract allowed for adequate staffing. However, the funding shortages during the first one- and one-half years caused a reduction in the contractor's staff levels and funding for subcontractors. According to Healthcom II personnel, it took months after the receipt of funds in March 1991 before the project returned to full staffing levels. Subsequently, several subcontractors did not perform work as originally conceived.

Healthcom II personnel also reported encountering difficulties in obtaining consultants and staff approvals. They stated that "six to seven people were turned down, sometimes multiple times," suggesting that USAID overestimated the number of people who knew the Healthcom approach.

However, USAID staff explained that the salary levels of proposed staff were exceptionally high, coupled with little proposed use of subcontractors (whose staff had originally been approved) rather than consultants. USAID staff also expressed concerns with the technical quality of many of the proposed staff and consultants.

Healthcom II personnel reported that an overly strict interpretation of the contract's level of effort (LOE) chart by a USAID contracts officer limited their ability to respond to project requirements. Healthcom II staff claim that the contracts officer for the first three years of the contract maintained that they could not deviate from the LOE chart, thus rendering them unable to add staff to meet new needs. Subsequently, it was agreed that the LOE chart was only illustrative, and that Healthcom II could hire staff according to its needs as long as it did not exceed the overall LOE limits.

In June of 1992, the Healthcom Project Director vacated this position (after having been Project Director since the beginning of Healthcom I) to become the Resident Advisor in Indonesia. The Deputy Director was then made Project Director for the remaining three years of the project.

B. RELATIONSHIPS WITH USAID/W, AND USAID'S TECHNICAL DIRECTION

Relationships between USAID/Washington and the Healthcom home office management were strained and rather difficult at times, particularly during the last three years of the project. In interviewing a wide variety of people, a picture emerged indicating that both sides had their frustrations with each other, feeling that they were not receiving necessary management support.

USAID had four CTOs for Healthcom over its five- and one-half year lifetime (listed in Annex A). Their length of time serving as CTOs ranged from six months to three years, and as Healthcom stated, "USAID project management varied from micro-management of staff selection to long periods of unavailability." At times when the contractor received little oversight and direction, delays in approving work plans and consultant requests resulted, and no midterm evaluation was conducted as originally proposed in the contract.

While it is obvious that it would be preferable for USAID to have no more than two actively involved CTOs manage any given project over its five-year lifetime, and that CTOs be available to the project without major demands on their time, the evaluation recognizes the difficulty of fulfilling such recommendations. However, the CTOs should at least be able to support the project when needed, and not be subject to a workload that makes it difficult to attend to the needs of the project for extended periods of time.

While the above circumstances clearly caused frustration, delays, and probably wasted time, it was difficult to find that this negatively affected the final output of the project. Even the CTO at USAID who felt strongly about Healthcom II's management said, "The Academy should be very proud of what they did. They did a wonderful job."

C. RELATIONSHIPS WITH USAID FIELD MISSIONS

Relationships with field missions appeared to be very positive overall. The missions contacted during this evaluation had high praise for the Healthcom project in general, and the professionalism and competence of its staff and consultants in particular.

One concern noted by some missions (Philippines and Burkina Faso), was the question of mission management/oversight of centrally funded projects. In the case of the Philippines, "Our concurrence was not formally requested by USAID/Washington for AED to conduct the Vitamin A activity in Cagayan de Oro." According to the mission, this "... did not allow us to monitor the activity as closely as we should have." They went on to say that "... the activity largely went without any Mission oversight."

The Burkina Faso mission noted that, "Mission staff provided the necessary support, but were not involved in day-to-day activities because it was an institutional contract. The Mission does not have resources to backstop each and every centrally funded project. It was more 'you guys do what you need to do and keep us informed.'"

IV. Contract Achievements

A. THE HEALTH COMMUNICATION METHODOLOGY

A major contribution of the Healthcom projects has been the five-step health communication methodology to promote behavior change:

Assess → Plan → Pretest → Deliver → Monitor

Healthcom II used this methodology with success in 13 different child survival and health areas, including:

- Control of Diarrheal Diseases
- Expanded Promotion of Immunization
- Family Planning and Reproductive Health
- Acute Respiratory Infections
- Breastfeeding
- Cost Recovery
- Vitamin A
- Child Survival (in general)
- Growth Monitoring
- Sexually Transmitted Diseases
- Onchocerciasis

Table 2 lists the countries and the interventions that were promoted with Healthcom II assistance in each long-term country.

B. ADAPTING THE METHODOLOGY TO NEW AREAS

The methodology has been adapted to include new types of interventions including marketing for hospital cost recovery (Egypt Heath Care Financing) and using behavioral modeling and tracking to improve health worker performance (Measles Initiative).

The Measles Initiative Project took place in Kenya, Burkina Faso, and Niger. These activities were collaborative efforts of three different USAID contractors to enhance measles immunization coverage. In all three countries, the HEALTHCOM methodology was used to improve health workers' effectiveness.

One of the lessons learned in behavior change from the Measles Initiative relates to both the behavior change of mothers in seeking health services and the behavior changes needed by health workers for mothers to change their behavior to seek services. The point-of-exchange for the interaction between health workers and clients was found to be crucial, but different for each of the three countries. Both good technical skills as well as positive attitudes toward their clients and job responsibilities are needed. Since no evaluations of actual use of services were finished, it is not known whether changes in health worker behavior led to increased use of services. A final evaluation however is proposed for Burkina Faso that BASICS could follow-up on.

The Egypt Health Care Financing Program was another new area for Healthcom II. The high quality of the work is shown through two issue papers written on the experience, and through the detailed project reports. The success of the program was also evident when three additional hospitals (not included in the original scope of activity to work intensively in only two hospitals) were so interested after learning about the project's activities, that they requested similar technical assistance in their own sites.

TABLE 2
Interventions Promoted by Healthcom II in Long-term Countries

Country	CDD	EPI	FP/RH[1]	ARI	BF	Cost Recovery	Vitamin A	Cholera	CS General	GM	Malaria
Burkina Faso		X									
Egypt						X					
Honduras	X		X	X	X			X			
Indonesia	X						X				
Mali	X	X	X								
Peru	X							X			
Philippines							X				
Senegal	X		X		X					X	X
Yemen	X				X				X		

[1] RH=Reproductive health

These new areas where the health communication methodology has been applied represent areas that could be replicated since both appear to have been quite successful. It would be useful to return to these projects one to two years following their completion to see if any changes in immunization rates (in Kenya, Burkina Faso and Niger) and marketing/financing (Egypt) resulted.

Healthcom II was asked by the USAID Division of Communicable Diseases (now Environmental Health) to provide technical assistance to the Vector Biology Control Project implemented by Medical Services Corps International on onchocerciasis (river blindness) in Nigeria. In addition to preparing a paper on lessons learned in communication that was presented at a planning workshop, staff assisted in the development of a health communication plan, media materials, and training of project staff.

C. PUBLISHING AND DISSEMINATING THE METHODOLOGY AND RESULTS OF HEALTHCOM II

Dissemination of contract findings was one of the major components within Healthcom II. Healthcom used several channels for dissemination of the methodology and the results of its activities. These included a book, Communication for Health and Behavior Change: A Developing Country Perspective, published by Jossey-Bass; several manuals, including A Tool Box for Building Health Communication Capacity, and Getting it in Focus: A Learner's Kit for Focus Group Research; videos, slides and associated guides; curricula; issue papers and scientific publications (see Annex D for a complete listing); and training modules. A detailed description of many of these publications is found in Annex E.

Selected materials were translated into Spanish, French, and other languages such as Bahasa Indonesian, as well as other local languages (e.g., Arabic). Dissemination of most of these materials appears to have been through distribution to a general mailing list of 1,500, and through distribution at workshops and seminars. However, more copies of materials were eventually distributed in response to individual requests than by the initial mailing. According to Healthcom, there were some 100-200 requests per month for publications, mostly from developing countries.

Surprisingly, it was not easy to learn about all the publications that had been produced by Healthcom II. It would have been helpful to have an easily accessible list of materials produced by the project, so that those interested would be able to easily locate relevant materials.

Several of the especially noteworthy documents that the evaluators were able to review included the aforementioned published book, the "Tool Box," the " Focus Group Kit," and the issue papers.

The published book, Communication for Health and Behavior Change: A Developing Country Perspective, is an excellent documentation of the lessons learned in many of the Healthcom activities as well as other health behavior change programs. Written for researchers and the academic community, it provides the scientific basis for the methodology. It helps to further the project goals by making the methodology easily accessible to many public health professionals working in other health projects. It has been distributed to all the health education units, schools of public health, and NGOs with which Healthcom worked. In addition, when requests were made from developing countries, copies were sent free of charge.

A *Tool Box for Building Health Communication Capacity*, is a manual designed to help managers of health communication programs improve their unit's organization and management. It contains "tools" to help organizations strengthen their communication skills and their ability to apply the communication methodology. It was completed during the last month of the contract and eight hundred copies were distributed in English. While the manual appears to be an excellent resource, it was not pretested due to shortage of time (in spite of Healthcom's methodology which includes pretesting as one of the necessary steps in communication).

The "Tool Box" was developed from the project staffs' belief in the need to document the "tools" considered to be useful from the experiences in Healthcom. However, the "Tool Box" does not appear to have been developed from the stated needs of the intended audience, i.e., "managers of health communication programs".

The focus group kit, *Getting it in Focus: A Learner's Kit for Focus Group Research*, was pretested under several different settings and revised accordingly. The high quality of the set illustrates the results of this careful pretesting. The evaluators found this set to be extremely useful and relevant to health communication and other fields as well. Comments received on the quality of the set by NGO staff in Peru and Honduras illustrate first-hand its impact. Another especially innovative publication is, "Unlocking Health Worker Potential: Some Creative Strategies from the Field." This provides excellent material to help health workers improve their skills communicating with mothers.

However, other than giving personal impressions, it is not possible to assess the impact that any of these or other publications produced by the project had. There was no evaluation strategy established to determine the usefulness of any of the materials disseminated by Healthcom II. Since the materials are quite expensive, and the dissemination costs (reproduction and postage) substantial, it would have been wise for the program to have built this into their dissemination strategy.

One method to evaluate the impact of previously disseminated materials is to take a sample of people who received selected materials and survey them to see how they have used them. This could be accomplished by BASICS to help them prioritize the Healthcom materials they are

currently distributing (see Annex F for the list of Healthcom I and II materials that BASICS is distributing).

Many of the scientific publications produced in Healthcom II were based on the results of research and evaluation activities initiated in Healthcom I. Much of the research compares results from several of the evaluations to illustrate patterns across different countries. The evaluation found it difficult to assess these publications since copies of many of the research reports could not be obtained. Some of the USAID technical staff closely associated with the program did not have copies. Additionally, the list of published papers produced from Healthcom II was found to be incomplete. Future communication programs should give more consideration to a dissemination strategy for project documents as well as scientific publications at the program's inception.

Because the project did not produce a leaflet nor an insert that illustrates all the products produced by Healthcom and their availability in different languages, it is conceivable that much of the output of this project may be underutilized. For example, the evaluation reports should be widely accessible to other USAID projects, the World Bank, and NGOs working in the same countries. The excellent manuals, videos, curricula, etc. need to be available to other child survival programs. How this will be done now that the project has ended needs to be considered. Currently, the information center at BASICS does not have a complete set of the materials produced under Healthcom II (such as the evaluations).

It would be useful to have BASICS and USAID (assisted by former Healthcom staff) develop plans to obtain all relevant documents and disseminate selected materials. However, it should be noted that doing so will have financial implications. The BASICS Project already has had a substantial increase in the number of requests for dissemination of Healthcom II materials.

D. LESSONS LEARNED IN BEHAVIOR CHANGE

Many of the lessons learned in relation to changing the behavior of health workers to help them become more effective caregivers are clearly illustrated in the manual *Unlocking Health Worker Potential*. Field experiences are described that illustrate the following lessons:

- "Health workers perform better when they feel appreciated by the community.
- Health workers should be provided with "tools" that are culturally appropriate, interactive, and pretested with target audiences.

- Health workers can be helped to overcome attitudinal problems.

  Health workers need help in overcoming their reluctance to engage mothers in two-way communication.

- Videos can be an effective tool.

- Health workers need training that helps them communicate effectively with mothers.

  Teach health workers as you want them to teach mothers. Listen to them and respect what they know.

- Health workers performance can benefit from exposure to a bigger health picture.

  Health systems need to show health workers that they are appreciated and contribute to overall public health goals.

- Mass media can motivate and provide continuing support to health workers."

Another unique area of behavior change that was identified in the Senegal project, is that of management capability. As programs become more decentralized (as was the case for Senegal), ways to improve management capability, in addition to the skills of local workers, becomes essential. This will be an area for future behavioral inquiry.

1. HARD-TO-REACH

One of the lessons learned in the SOMAVITA project in Indonesia was to emphasize communication channels that reach the "hard-to-reach" in order to increase coverage above 50 percent. They found that village administrators were important in motivating the village health volunteers (kaders) and reaching the "hard-to-reach" families who are not touched by mass media and are less likely to use MCH services (*Annual Report #3*, p. 19). They also found that the Fatayat volunteers were more likely to reach the "hard-to-reach" children, ages three to five, who are rarely brought to the local health post (posyandu).

2. PREVENTIVE VS. TREATMENT BEHAVIORS

As stated in *Results and Realities*, preventive behaviors are more complicated and difficult to affect than treatment behaviors. Treatment is usually promoted by a salient event, is limited in time, and produces visible results, while preventive behaviors often require changes in daily routines (hand washing) with no immediate impact. Thus, preventive behaviors are more difficult to change, and require different types of communication messages. The results of Healthcom

suggest that interpersonal communication may be more important for changing preventive behaviors. The use of community volunteers who can reinforce such behaviors may prove to be essential.

3. MIXING OF STRATEGIES

One of the clear lessons of Healthcom was that multi-channel communication strategies (mass media, direct mail, and face-to-face interaction) are needed to contact all segments of society. While face-to-face interventions were often found to be more effective than mass media (such as radio), its overall impact is less because radio reaches a greater number of people.

A clear relationship has been shown of the importance of addressing health workers in addition to mothers in a communication program. If health workers are giving out information contrary to the messages of the program, this can severely limit the program's effectiveness.

4. APPLIED RESEARCH: FINDINGS IN BEHAVIOR CHANGE AND MAINTENANCE

The Applied Research Agenda specified within the contract included research on key questions with particular relevance for the future of health communication programs. Examples of 11 possible research questions were given. The *Healthcom II Final Report* states that Annenberg's analyses of the country-level evaluations provides answers to five of the 11 questions.

Some of the major findings regarding behavior change and maintenance of the changes based on these evaluations have been summarized in an article written by Rasmuson et. al., in *Development Communication Report*. These include the following:

- Health communication has been shown to result in increases in immunization coverage, in ORT use, in increasing the percent of women breastfeeding within six hours following child birth, and in Vitamin A capsule distribution.

- Health communication is more effective when combined with changes in health worker activities.

- Health communication can not only increase demand for services, but also timely use of services (such as for immunizations).

- Interventions such as promoting immunizations are easier to affect with health communication techniques than other interventions requiring more difficult tasks, such as appropriate home mixing of ORS. Increasing immunization usage is easier

from initially lower levels, than for higher levels, where the target group tends to be the hard-to-reach segments of society.

- Interpersonal communication is often more effective than mass media, but because the exposure is generally lower for face-to-face interventions, the overall effect is less when measured in terms of behavior change.

- In order to sustain behavior change, some level of communication must be maintained.

Some other findings related to the questions asked in the contract are:

- *What do mothers know and why do they believe and act as they do regarding their children's health?*

  Mothers generally seek treatment for illnesses that they consider dangerous, but often seek treatment for ARI that is treatable at home. They can be taught to recognize signs of lower respiratory infections, and then seek treatment.

  Mothers try to feed children who are sick and are concerned when their children are anorexic. Thus, just educating mothers on the need for feeding during illness will not work. Mothers need to be helped to find means to address the anorexia.

- *What influences and changes mother's behaviors?*

  There are numerous antecedents and consequences that affect mothers' behaviors, and these can be reinforced or changed to enhance the desired behaviors. Some of these are clearly illustrated by the video, Will She Return?. This video demonstrates the factors that affect mothers in seeking immunizations for their children.

- *How do changes become recurrent?*

  Sustained behavior needs to be encouraged by sustained activities.

- *How does the community context and interpersonal health contacts affect behavior?*

  Community norms are very important in establishing the behavior of individuals, therefore changing the community's knowledge and behavior is essential. Mass media and use of local community members (such as community volunteers) are two effective ways to do so.

- *How can the methodology be simplified and adapted?*

  The Healthcom project attempted to work with local counterparts to adapt the methodology. The materials produced by Healthcom (including the "Tool Box" and "Getting in Focus") were means used to simplify the methodology so that it could be used by others.

- *What is the optimum mix of communication channels?*

  The results of the evaluations show that the higher number of channels, the more successful the intervention, generally speaking. However, because cost analyses were never conducted, the extent to which each additional channel is cost-effective is not clear.

- *What level of evaluation capability can be institutionalized within a country?*

  In Indonesia, the curricula on research and evaluation developed for the six schools of public health suggest that there certainly is an ability for evaluation to be institutionalized in this country. As with many other health programs, evaluation plays a lesser role than the intervention itself. Thus, often its institutionalization is less likely to occur.

- *Can communication approaches be systematically applied to train health providers?*

  The Measles Initiative projects in Kenya, Burkina Faso, and Niger strongly suggest that the Healthcom methodology can be used to train health workers effectively. Whether this results in increases in immunization coverage, however, is not known since evaluations measuring this were never conducted. An important lesson learned is that health workers need to be treated as the target population and put at the center of the communication message (as is suggested for mothers), in order to address the constraints that they face.

- *What incentives can be built into a program to motivate and sustain active involvement of health communication staff?*

  While increasing salaries usually works, this is often not sustainable. Some of the suggested means that are more sustainable include providing other incentives such as new equipment (e.g., desk-top publishing computers have been extremely useful in the Honduras project), or policies that health communication staff can point to when new program managers are recruited.

- *What are the minimal essential elements of an effective formative research program?*

  The "Tool Box" outlines what elements are needed.

- *How can demand created by an effective communication program be met with an appropriate and efficient supply?*

  The lessons learned from Healthcom seem to point to the essential need of any health communication program to include active participation of the health sector so that supply will be available.

E. THE ROLE OF EVALUATIONS

1. EVALUATIONS OF HEALTHCOM I PROGRAMS

A major component of Healthcom II was the analyses of data collected on Healthcom I programs. Detailed and well-designed evaluations were conducted and data analyzed by Annenberg, and a major proportion of Healthcom II total funding was spent on this work. However, other than producing many excellent scientific publications, little seems to have been done with these evaluations. There was no dissemination strategy for widespread distribution and even those working in other child survival programs were not made aware of them. Moreover, what was distributed, i.e., results presented to the general public in *Results and Realities*, and in project annual reports, were quite selective. Discussions were limited primarily to findings that were positive, even if they did not represent the most important issues in the findings. For example, the positive results on ORT use were cited for Lesotho and Honduras, but the lack of increases noted in Indonesia and Zaire were not reported. The positive results for rates of immunization coverage were given for the Philippines, but unchanged rates in Lesotho went unreported. Positive results from Jordan on the increase in the proportion of women who breastfeed within six hours were given (no results were given for less time that), but the lack of impact on exclusive breastfeeding rates, which was the more important indicator in terms of health or child spacing goals, was not mentioned.

It would have been useful if there had been more analyses about why changes were seen due to the interventions in some countries but not in others, since they all used the Healthcom methodology. Was it related to costs and funds available (we are not given the information), the types of health services, the management structure of the MOH and the project, or the time available for the activities?

While each of the evaluations included a section on institutionalization, there was no paper produced to summarize these findings, which would have helped Healthcom II assess its ability to institutionalize its activities.

Table 3a summarizes the number of evaluations that were completed in Healthcom II. For many, the data had been collected during Healthcom I, but were analyzed in Healthcom II.

CDD Activities

The evaluation of the West Java project showed that while the program was quite intensive (three channels of radio, use of counseling cards, and mobile films), there were no increases in the use of Oralit (24% administered it for diarrhea during the last two weeks), although knowledge about it increased. Volunteer health workers did however increase their use of Oralit during their treatment of diarrhea. In Central Java, there was little impact of the program on Oralit use. In Zaire there was no increase in ORS use. In Lesotho, the results were more impressive, with the use of sugar and salt solution or ORS increasing from 39% to 60% and in Ecuador from 5% to 20%.

EPI Activities

Measles immunization increased in urban Philippines from 42% to 65% from 1988-1990. Immunization rates in Ecuador increased from 20% to 43% for children under one year. However, immunization rates, which were relatively high to start with, did not increase in Lesotho. In Zaire, immunization rates increased only slightly from 60% to 65%.

Vitamin A Activities

In Central Java, the ROVITA pilot project resulted in substantial increases in Vitamin A capsule consumption, but only in villages that had a health post (24% to 40%). There was relatively low exposure to the interventions (radio: 25% heard a radio message during the campaign; banners: only 5% remembered seeing a banner during the campaign). According to DOH statistics, the national SOMAVITA project resulted in expanded capsule consumption by six million more children between 1992 and 1994.

Breastfeeding Promotion Activities

In Jordan, the proportion of women breastfeeding within the first six hours after birth increased among women who delivered at home or at public hospitals. However, breastfeeding did not increase for women delivering in private hospitals (27% of the population). No differences in the proportion exclusively breastfeeding were seen in any group.

2. HEALTHCOM II EVALUATIONS

The contract (p. 25) stated:

> "the contract can in many ways be seen as a major effort in evaluation and research related to the institutionalization of communication methods in host country institutions and the sustainability of behavior change. Thus, the generation of evaluative information is one of the basic objectives of the contract . . . an overall set of evaluation criteria will be proposed in the initial work plan to be reviewed and approved by the . . . technical officer and technical advisory group."

While clearly stated in the contract, the initial work plan did not contain a set of overall evaluation criteria for the project as required. This may have inhibited the project's ability to conduct these evaluations. For example, by the end of the project, out of nine less-intensive long-term countries (see Table 3b), there were only three completed final evaluations (Honduras ARI Program, Indonesia Vitamin A Program, and Yemen Rural Mothers Program) and one completed in draft form (Philippines). There were rough drafts of other evaluations which are not suitable for distribution.

TABLE 3a.
Evaluations Conducted In Healthcom I

Country	Evaluation	Report
Healthcom I Activities		
Central Java, Indonesia	x	Completed in Healthcom II
Ecuador	x	Completed in Healthcom II
Honduras	x	(Completed in Healthcom I),
Jordan	x	Completed in Healthcom II
Lesotho	x	Completed in Healthcom II
Nigeria		
Papua New Guinea	x	Completed in Healthcom II
Philippines (National	x	Completed in Healthcom II
West Java, Indonesia	x	Completed in Healthcom II
Peru	Project closed	
Zaire	x	Completed in Healthcom II

The social marketing campaign in the Philippines included a mix of radio, TV/cinema, and interpersonal communication through training of health and agricultural workers, teachers, and community volunteers. Results of the evaluation, which included pre-and post-tests in the intervention area and in a similar control area, showed an increase in the incidence and frequency of consumption of Vitamin A-containing-vegetables. This evaluation clearly defined the reach of the interventions, including the numbers of workers trained and school children reached, but it did not give the numbers in the target population expected to be affected. Because of the heavy involvement of the local counterparts (the Nutrition Center in the Philippines), the draft is likely to be completed and circulated within the Philippines. The results of the evaluation are important as it has created major interest among members of the local Micronutrient Action Team.

The ARI pilot program in Honduras included health worker training, education of mothers by health workers, distribution of a comic book, and local contests held within communities. The results of both the qualitative and quantitative research were reported. They illustrated improvements in health workers' and mothers' abilities to recognize and respond to severe symptoms of ARI in children. Because this was a pilot effort, the next step planned is to test whether the intervention could be implemented at a national level. To date, however, this has not happened. The evaluation of the program was published in one of the Healthcom II issue papers and in the *Bulletin of the Pan American Health Organization.*

The Indonesia Vitamin A Program was the largest activity conducted by Healthcom II. Based on the results of the pilot project conducted in Central Java under Healthcom I, the government of Indonesia decided to expand the program to the national level, targeting 13 of the provinces with the highest level of Vitamin A deficiency. Pre- and post-surveys were conducted in Central Java and West Sumatra in 1993 and showed substantial increases in capsule consumption among young children.

This is an example of one of the more successful projects, as it expanded from a pilot to a national effort. However, concerns have been raised by Healthcom staff as to whether the increases will continue given the change in leadership of Helen Keller International (HKI), the NGO leading the project. If this is in fact true, this has major implications for project sustainability. If the program is not maintained because of a change in NGO staff, then we need to learn why.

Rapid assessment surveys of the urban FNU volunteers showed increases in capsule consumption from 50% to 69% in East Jakarta and 21% to 45% in North Jakarta among a population of 16,000 children. The cost study for the FNU in Indonesia was an excellent means to assess the costs of using volunteers to extend health services and provide capsules to children not previously reached. It should also include the number of volunteers enrolled in the program and the numbers of children who received Vitamin A capsules.

TABLE 3b.
Evaluations Conducted in Healthcom II

Country	Evaluation Conducted	Report
	Healthcom II Activities	
Burkina Faso	IEC observational research, three months of observations after training; no evaluation of impact on immunizations conducted **Suggested for BASICS**	No draft available for review
Egypt	None conducted	
Honduras	ARI, qualitative and quantitative	Results published in Issue paper "Nothing to Sneeze At"
Indonesia	Baseline in 1991 and End Line in October 1993 To assess impact of the Fatayat Urban Vitamin A Distribution Program in East and North Jakarta	Results reported in annual reports Results reported in annual report Draft of paper on costs of this project written
Peru	None conducted	
Philippines	Two cities in Mindanao (experimental and control) 300 kids 1-6 in each area Baseline: August/September 1994 End line Survey: February/March 1995	Draft of evaluation written
Yemen	November 1991, July 1992	Team visited several villages; details of results not given in annual reports Published paper on this topic

The Yemen Rural Mothers Program was evaluated through surveys conducted in four intervention villages (out of 30) and two control villages. We were not able to obtain a copy of the evaluation, though it had been published in a scientific journal. *Annual Report #3* stated that trained village volunteers "had sufficient skills, knowledge, and motivation to disseminate health information . . . and many had contacted villages" to do so, while mothers in control villages, who only heard health messages on television, "were inadequately prepared to provide information to others." The evaluation does not appear to have assessed changes in behavior so we do not know the impact of the program on health practices.

Many of the long-term projects in Healthcom II did not have evaluations, and often not even final reports (Mali). For other projects (Peru, Senegal), the final reports were too brief to give sufficient information. However, the final report on the Egypt project was quite detailed providing useful information for similar efforts. For future projects, it would be useful if there was more detail given in the final reports, so that other organizations working in the same areas could benefit from the experiences.

Most evaluations and reports did not illustrate the numbers of people reached by the project. In future projects, it would be useful to have the expected target population given and the estimated numbers reached by the interventions. This would allow for an assessment of the coverage level of the intervention.

3. COST-EFFECTIVENESS ANALYSES

A major gap in the evaluation process was in the assessment of cost effectiveness. While cost-effectiveness analyses were to be included in the contract, little was actually done in this area. Only two analyses were conducted, one of the Philippines immunization program and one of the FNU project in Indonesia. The Philippines evaluation was considered by AED to be technically inadequate and was not circulated. The FNU evaluation was available only in draft at the time of this evaluation, and it was not clear whether the data would ever be finalized and disseminated, particularly since the project was ending. No other cost analyses of implemented projects were completed, nor was guidance provided on how to project costs for health communication activities. Even the procedures manual in the "Tool Box" did not discuss costing.

An early promising step in this area was when one of the project's subcontractors, Birch and Davis International, conducted interviews with USAID staff to find out what they viewed as important in assessing the costs of health communication programs. Their summary of these interviews could have been an important first step of a process designed to develop a series of cost-effectiveness analyses instruments for all long-term country programs, but unfortunately there was no follow-up to the report.

The evident need to include the assessment of costs from the initial stages of project activities should be considered for any future communication efforts. It may be necessary to include a

health economist or other professionals familiar with cost analyses on the project staff whose responsibilities include cost analyses of country programs. It appeared that the Healthcom II financial officer had too many other responsibilities that precluded the ability to work on cost-effectiveness analyses at the level required.

AED acknowledges that cost-effectiveness analyses were one area in the program that was consistently difficult to achieve. Future projects need to build in systems to effectively handle this important area.

F. ROLE OF TRAINING

Training has been a major priority for Healthcom II. In nearly every project, training of health workers was conducted. In addition to the training of staff in the health education units (described in G.1.), training of health workers has been widespread.

Training was the principal focus for the African Measles Initiative. In Burkina Faso, a workshop was held for IEC training of health workers and the module, "Talking with the Community about Immunizations," was adapted. In Kenya, through Healthcom concept testing with health workers, it was observed that missed opportunities for immunizations were occurring because health workers did not have an explicit directive from the EPI program. Subsequently, the official government policy was changed (a major means of institutionalization), and technical updates were prepared for health workers as a means of providing ongoing training in the new policy. In Niger, an IEC training module was prepared that was directed at skills enhancement and described the costs and benefits of adopting new skills to health workers.

In Egypt, training in marketing was an essential component of the cost recovery project. One of the lessons learned was the need to enhance the impact of the training by ensuring continuity of marketing support between training sessions. This was done by combining group training activities with individualized technical assistance to develop and implement the marketing program.

However, as with the other components of the program, there is little information on the long-term impact of the training. Did it result in changes in health workers' and mothers' behavior several months after the training? Was training alone a sufficient intervention or were changes in the supervisory system needed? Because evaluations of most of the programs did not include analyses of behavior change associated with the training, the answers to these questions are not clear.

G. INSTITUTIONALIZATION AND SUSTAINABILITY

1. PROJECT GOALS

Institutionalization is a worthy and necessary goal, but one that is difficult to accomplish, and even harder to measure. Institutionalization is a continuing process and not a goal that can be achieved in a limited time span. There are a number of issues that make institutionalization particularly difficult, including the limits of time, stability of collaborating institutions and their staff turnover, and continued funding after the donor's program ends.

As stated at the beginning of this evaluation, one of the purposes and expected outcomes listed in the scope of work of the Healthcom II contract was:

> "Institutionalizing effective communication capability in appropriate public and/or private host country organizations."

While the contract also stated that the contractor should establish criteria to measure institutionalization and sustainability within the first year's work plan, this was never done. However, the contract listed a series of issues that should be included to measure institutionalization. This original list was reviewed by the evaluators to assess the level to which Healthcom II accomplished the goals of institutionalization.

Table 4 summarizes the strategies listed in the contract to institutionalize the communication methodology and the countries where these strategies were included in program activities. They include:

- Staffing of the health education unit within the MOH.
- Participation of the private sector in the promotion and distribution of communication messages as well as supplies and materials.
- Functioning public-private sector partnerships.
- Incorporation of child survival concepts and messages in formal educational curricula and in health professional training.
- Strengthening the capacity of universities to teach social marketing.
- A HEALTHCOM model that can be quickly and effectively adapted and replicated.
- Changes in program policies, planning, staffing, and budgets.

Staffing of the Health Education Unit

A particular emphasis of Healthcom II was to enhance the professionalism of health education units through intensive training. Training of MOH staff was conducted in Indonesia, Honduras, Peru, Mali, Senegal, Niger, and/or through the participation of staff in courses given by The Johns Hopkins University (Philippines, Indonesia, Honduras).

TABLE 4
Strategies Used in Healthcom II Countries to Institutionalize Activities in Long-term Countries

Country	Health Education Unit	Promotion/ Distribution of Communication Messages by Private Sector	Public-Private Sector Partnerships	Education and Training Curricula	Adaptable Healthcom Model	Changes in Policies, etc.
Burkina Faso				X	X	
Egypt		X		X	X	
Honduras	X	X			X	X
Central Java, expanded to nationwide 1992	X	X	X Worked with 40 NGOs	X	X	X
Mali	X				X	
Peru	X	X	X		X	X
Philippines		X	X	X	X	
Senegal	X				X	
Yemen	X				X	

In addition to the training of health education unit staffs, Healthcom II helped to strengthen the units by working with MOH staff in writing job descriptions (Mali); developing a policies and procedures manual for planning, implementing and monitoring communication programs (Honduras); and developing guides on the management of IEC activities, including the basic steps of planning, implementing, and evaluating IEC projects (Senegal).

Consistently, Healthcom II found that there was often significant staff turnover within the institutions that received TA. For example, in Honduras, there were three new directors of the Division of Health Education within three years, and seven within ten years.

High staff turnover was also a problem in Mozambique. For example, USAID asked for a consultant to study the network of traditional healers to propose strategies for their incorporation into government health programs, and ways to transfer research and assessment approaches to MOH staff. Six months later the mission requested the same consultant to return to repeat the work because all of his previous counterparts at the MOH had been transferred to new positions.

Although Healthcom has had many years to consider this issue, it has been difficult to find appropriate solutions. They suggest that working with health education units may not be the most efficient use of resources. In many cases, they have worked within one particular technical office (such as CDD or EPI), training the staff to conduct communication activities. Another means used to address this problem would be assistance to MOHs to develop policies and procedures manuals that would remain within the MOH even when government changes bring in new staff. In Peru and Ecuador, Healthcom's TA to assist in the government's own initiative in developing policy statements was an attempt at institutionalization. As stated by the CTO at the USAID mission in Peru:

> "The policy has had a long-term impact by ensuring that health communication is seen as a valid means of improving health. It has validated the health education unit's role to be that of health promotion, not as a public relations arm of the MOH, which it had been in the past."

While the MOH in Peru was not interested in receiving TA on health communication during the years of Healthcom I, there now seems to have been a shift and the TA provided by Healthcom II was very well received. The inclusion of health communication within the new World Bank-MOH health program can be seen as an indicator of this successful institutionalization of communication efforts.

In March 1995, Healthcom II assisted the Health Education Unit in the MOH in Honduras to draft a "Communication Policy Decision Paper" for the Minister of Health to sign, which would formalize a health communication policy. It is too early to know the impact of this policy.

One of the lessons from the problems associated with working with health education units is that it seems to be most appropriate to work with many institutions within a country, and not just with a single agency. Healthcom II has tried to do this when possible by working with a variety of public and private advertising and research firms and educational organizations as well as with the government (*Annual Report #3*, p. 72). However, because there were no comparative analyses made of this approach, we do not know whether this is more successful than working strictly with health education units.

Promotion of Communication Messages by the Private Sector

A particularly impressive collaboration with the private sector was Colgate-Palmolive in Ecuador. The MOH and Colgate worked together on the development of materials on purification of water to prevent cholera, with mass media efforts funded by Colgate. It would be interesting to do a follow-up evaluation to assess whether coordinated effort continues between the MOH and this private company.

Other for-profit links used by Healthcom were advertising agencies hired in numerous countries (e.g., Honduras, Indonesia) to work with the MOH on development of communication messages. While the use of these agencies has helped to enhance the output of the campaigns, we have little information on whether it has led these agencies to continue to work on social marketing. Surveys of agencies that worked on Healthcom I and II would help illustrate whether this occurred. A new project design should include these similar assessments to guide the project's efforts.

Public-Private Sector Partnerships

In Central Java, Healthcom II worked with the NGO, Helen Keller International, the FNU Women's Movement, and private universities. Survey Research/Indonesia conducted quantitative and qualitative research for the national program. In the Philippines, Healthcom subcontracted with the Nutrition Center of the Philippines for research, materials development, and production. In Peru, Healthcom subcontracted with The Instituto de Investigacion Nutricional, a non-profit research organization. All of these seem to have been quite successful collaborations and useful models to consider for the future.

Curricula Development

There were many curriculum support activities within the West Java, Indonesia Healthcom II project. Modules were developed on health education for diploma and masters nutrition education programs sponsored by the Southeast Asian Ministers of Education Organization (SEAMEO). Both courses are structured around the five steps in the Healthcom methodology. In addition, an agreement was made with the University of Indonesia and five other schools of public health to provide support for strengthening existing courses in health education.

Healthcom worked with the International Center for Advanced Studies in Communication for Latin America (CIESPAL) on the design and implementation of two workshops on social marketing and health communication. They plan to use the course curriculum for future training given by CIESPAL, especially in the Andean Region. Healthcom also worked with The Nutrition Institute for Central America and Panama (INCAP) on the development of a master's level course on social marketing. INCAP reported that the product was "excellent" and that they are presently teaching the course.

As a means of providing curriculum support, Healthcom worked with staff of the College of Public Health at the University of the Philippines and sent a senior faculty member to a Johns Hopkins University (JHU) workshop. Several faculty members from Indonesian universities that provide graduate training in public health were also sent to JHU.

Adaptable and Replicable HEALTHCOM Model

In all countries where Healthcom had long-term programs, the model was adapted and replicated for many different types of interventions. The monitoring and evaluation component of the model was less likely to be implemented due to the short time period allowed for project implementation. However, more could have been done on monitoring of activities to show changes in process indicators, as was done in the Philippines during a short time period.

Because USAID country programs seldom have time periods beyond two years, mechanisms need to be established from the contract's inception to encourage continued monitoring after USAID funding has ended. Central funds could be utilized when the project is still ongoing, and monitoring could be achieved through counterpart activities once the central project has ended. Also, work with a local non-profit NGO with a history of working in a particular technical area, ensures a likely continuance of monitoring activities at the community level.

Changes in Program, Policies, Planning, Staffing, and Budgets

In Central Java, the project helped produce and distribute Indonesia's first official Vitamin A guidelines handbook that outlines formal government policy on the distribution of Vitamin A capsules. As mentioned above, in Peru and Ecuador, national communication policies were adapted based on the work of Healthcom.

In Yemen, Healthcom II involved key officials from seven governorates in developing health education plans. This was the first time that health education was developed at the governorate level (*Annual Report #2*). In Indonesia, the Department of Health allowed Vitamin A capsules to be distributed outside of the regular health post system, which represented a major policy change related to Healthcom II's efforts.

There were no analyses conducted by the project that would illustrate whether there were changes in staffing or budgets associated with Healthcom II efforts. This would have helped to provide information on longer-term impacts.

2. *LESSONS LEARNED IN INSTITUTIONALIZATION AND SUSTAINABILITY*

In Indonesia, the SOMAVITA project used government budgets for the long-term sustainability of broadcast and outreach media. Healthcom II funded development and testing of materials,

some limited broadcasting, and technical assistance. All radio and national television broadcasting was funded by the government or received free-of-charge. Healthcom II staff report that the involvement of multiple segments of the government and community leadership at the provincial, district, and village level, will help to sustain the program.

One of the clearest examples of institutionalization and the overall support that health communication has had, is demonstrated by the number of bilateral and international agency (UNICEF, World Bank) child survival projects that include health communication. The work of Healthcom and a number of other communication projects have contributed to the incorporation of this methodology by other bilateral and international agencies.

Whether the achievements reached from efforts initiated through Healthcom II will continue in the target countries, will depend somewhat on the continued level of external funds available. Few developing countries are able to continue many of the training efforts because the interpersonal communication training necessitates maintenance of ongoing supervision and support. Support systems in health worker programs are generally poor due to lack of funds and logistics for supervision, as well as inadequate supervisory models. This suggests that support for training programs should be combined with assistance in developing efficient supervision systems that can provide the ongoing training needed, but function within the MOH budget. Continued support for stand-alone training may not be the most appropriate activity for USAID to fund.

The sustainability of media efforts is even less likely because of their high costs. However, the methodology of how to conduct well-run health communication projects is now easily available through the materials developed and produced by Healthcom I and II. If funding can be obtained from government budgets, the private sector, or donors, there could be continued sustainable results.

There are many examples of how Healthcom II attempted to institutionalize its activities through work directly with non-governmental organizations and communities. Some of these activities may continue without donor support. In Indonesia, in a special urban Vitamin A initiative, work was done in collaboration with Fatayat Nadhaltul Ulama (FNU), an Islamic women's volunteer organization with six million members nationwide. Since the project attempted to strengthen FNU's institutional capability in social marketing and health communication, FNU could replicate the efforts throughout other cities in Indonesia. The cost study completed by AED can be used by the FNU to help determine whether they can replicate the project in other areas of Indonesia.

V. Conclusions and Recommendations

A. CONCLUSIONS

In terms of contract performance, the Healthcom II contractor complied with the deliverables specified in their amended contract, and in only some cases, exceeded the original contract's requirements. This led to a program output that has received overall high praise.

As noted in this report, some difficulties did exist in the areas of contract management. However, despite these circumstances, it was difficult to find that the final output of the amended contract was affected in any substantive way.

Healthcom II provided technical assistance for numerous successful health communication interventions in over 30 countries. The research component analyzed evaluations of Healthcom I interventions, helping to provide needed information on the development of successful programs. Based on the broad experience gained through 17 years of USAID support, Healthcom II produced and disseminated many types of materials to help others conduct health communication programs in the future.

While more could have been done in the areas of evaluation of long-term project impact, cost effectiveness, and the question of institutionalization, overall, the project helped improve the state of health communication in many child survival sectors throughout the developing world.

B. RECOMMENDATIONS

Based upon the investigation and findings of this evaluation, the following recommendations are suggested relative to certain follow-on activities as well as future work in this area:

1. **While institutionalization did take place due to the Healthcom II contract, the issue was never clearly assessed.**

   Future projects should consider assigning one individual to track the overriding issues of institutionalization and sustainability and make recommendations to the project on means to achieve sustainability. Their role would be to ensure that programs do get evaluated and activities institutionalized (to the extent possible). In order to effectively

accomplish this, a set of clear, realistic goals and criteria, having specific objectives and outputs, need to be established for "institutionalization." These criteria, goals, and outputs should be included within the project's contract.

2. **Institutionalization is a continuing process, not a goal that can be achieved in a limited time span.**

   A repeated theme during interviews for this evaluation was that the actual time frame for implementing an in-country program (during a five-year contract), is one- and one-half to two-years in length, due to the approval and contracting process, fielding resident advisors, and leaving time to evaluate and close down program activities. This is not a long enough time period to establish any degree of institutionalization.

   USAID needs to consider this in the design of future communication programs. Arranging to continue the project through counterpart activities after the central project has ended is one possibility.

3. **USAID should attempt to have no more than two CTOs manage a project over its five-year lifetime.**

   While it may be unrealistic to expect that CTOs can provide the majority of their time to a single project given the shortage of staff at USAID, the CTO should not be subject to a workload that makes it difficult to provide support to the project when required.

4. **Healthcom demonstrated some success in mobilizing groups (such as UNICEF, WHO, PAHO, local NGOs, etc.) to common ends using the communication methodology.**

   Future programs should ensure that this effort continues.

5. **A future program should attempt to develop regional approaches.**

   This has been done with some success by SOMARC, the Social Marketing for Change Program (a contraceptive social marketing project). A number of interventions lend themselves to a regional approach such as AIDS and cholera.

6. **Because of the inherent problems in funding with MOHs, it would be useful for a future project to consider ways to institutionalize health communication methodology with the private sector. Concurrently, future projects should consider ways to convince policy makers and donors that preventing illness is cheaper and more effective than treating illness.**

This would provide an incentive for MOHs to commit more of their limited budgets to health communication.

7. **Cost-effectiveness studies should be included in future activities, and guidelines prepared on how to project expenditures for health communication activities.**

8. **Future projects should focus on how to maintain behavior changes, as well as on how to obtain changes in multiple behaviors related to different outcomes, such as improving feeding, weaning food storage, and hand washing.**

9. **In future activities, it would be useful to build in evaluation criteria from the start.**

   Such criteria could include follow-up of previously trained staff to track what they are doing several years after training, and whether they continued to use the IEC methods even though they may have left previous jobs. It could also include assessing whether curricula or modules that had been jointly developed were used subsequent to the original activities. For example, modules were developed for workshops with CIESPAL in Latin America and SEAMEO in Asia. Were they used after the original workshops?

   An analysis would also be useful concerning why changes in health practices occurred due to the interventions in some countries but not in others, when they used the same methodology.

   Future health communication project reports and evaluations should include information on the size of the target population and the estimated proportion reached by the intervention.

10. **Due to the high costs of writing, printing, and disseminating materials, it would be worthwhile to evaluate the impact that the previous disseminations have had, including an analysis of which materials were most useful.**

    This could be done by taking a sample of people who previously received materials, and surveying them to see how they have used the materials and which materials were most useful. Subsequently, a list could be published of the useful materials produced by Healthcom I and II. BASICS and USAID could then develop plans for marketing and disseminating these materials.

11. **Field test the "Tool Box", revise it, and consider translating it into Spanish and French (and perhaps Arabic and Bahasa Indonesian).**

Annex A

List of Individuals Contacted

List of Individuals Contacted

Name	Affiliation
Connie Carrino	USAID/Washington
Robert Clay	USAID/Washington
Holly Flutey	USAID/Washington
Melody Trott	USAID/Washington
USAID MISSIONS	
Jatinder Cheema	Burkina Faso
Stan Terrell	Honduras
Barbara Spaid	Indonesia
Susan Brems	Peru
Marichi de Sagun,	Philippines
Dr. E. Voulgaropoulos (by fax)	
INTERNATIONAL ORGANIZATIONS	
WHO/EPI/Geneva	Dr. John Clements
PAHO/EPI	Daniel Epstein
INCAP	Magda Fischer
HEALTHCOM AND FORMER STAFF	
Alan Andreasen	Consultant (Georgetown University)
Joseph Diedrich	Financial Manager
Sandra Del Prado	Senior Communication Advisor
Judith Graeff	Senior Communication Advisor (now with BASICS)
Reynaldo Pareja	Senior Communication Advisor
Mark Rasmuson	Former Project Director, Resident Advisor Indonesia (BASICS)
Anne Roberts	Senior Communication Advisor

Will Shaw	Project Director
William Smith	Senior Technical Director, Executive Vice President, AED
Cecilia Verzosa	Senior Communication Advisor (World Bank)
SUBCONTRACTORS	
Robert Hornik	Annenberg School for Communication, University of Pennsylvania
Dennis Foote	Applied Communication Technologies
Henry Cole	The Futures Group International
Dana Faulkner, Robert Porter	Porter Novelli
OTHERS	
Karen White	BASICS

Annex B

Materials Reviewed

Materials Reviewed

Project Documents

Healthcom I Final Evaluation
Monthly reports (Oct. 1989-March 1995)

Annual Report # 1 (Oct. 1, 1989-Sept. 30, 1990)
Annual Report # 2 (Oct. 1, 1990-Sept. 30, 1991)
Annual Report # 3 (Oct. 1, 1991-Sept. 30, 1992)
Annual Report # 4 (Oct. 1, 1992-Sept. 30, 1993)
Annual Report # 5 (Oct. 1, 1993- April 30, 1995)
Final Report (May, 1995)
Year 1 Work Plan - Dec. 1989
Year 2 Work Plan - FY 1991 (no date)
Year 3 Work Plan - FY 1992- Oct. 1991
Year 4 Work Plan - FY 1993

Manuals/published books

Communication for Health and Behavior Change: A Developing Country Perspective
A Tool Box for Building Health Communication Capacity
Getting it in Focus: A Learner's Kit for Focus Group Research
Notes from the Field: Communication for Child Survival

Videos/slides and guides

Will She Return?
Developing a Social Marketing Strategy for Communication Programmes
Things Have Changed

Issue Papers

Unlocking Health Worker Potential
Developing a Marketing Function for Health Care Facilities, and
The Measurement of Patient Satisfaction in Health Care Services: A practical guide
Results and Realities: A Decade of Experience in Communication for Child Survival
Nothing to Sneeze at: Integrating Research into the Honduran ARI

Curricula

Appropriate Research Technology

Training manuals

Guide to Using Radio Spots in a National Communication Program

Evaluations

Healthcom I
- Zaire
- Jordan
- Indonesia: Central Java, West Java
- Lesotho
- Honduras (ACT post-survey)
- Ecuador
- Philippines
- Papua New Guinea

Healthcom II
- Philippines Vitamin A
- Honduras ARI
- Indonesia cost study of FNU Volunteers

Final reports-Healthcom II
- Peru
- Egypt

Annex C

Healthcom II Final Evaluation Scope of Work

Healthcom II Final Evaluation Scope of Work

I. CONTRACT PERFORMANCE

To what extent has the Project completed the deliverables specified in the Scope of Work of the prime contract (and any subsequent contract amendments) and delivery orders between USAID and the Academy for Educational Development? To what extent did the Project go beyond the specified deliverables?

Has management and financial tracking been adequate to meet the Project's needs? Are there any particular strengths or weaknesses that can inform future activities?

II. CONTRACT MANAGEMENT

Contractor

Has there been an appropriate match between contract requirements and staffing over the life of the Project? If not, how could this match be improved in future communication/IEC activities?

How has the project managed relationships with USAID/W and field Missions? What worked and didn't work? What could be done to improve these relationships in future activities of this kind?

USAID/Washington and USAID/Field

How well did USAID technical direction and monitoring of this Project work? Did the staff feel that they had enough direction? Was there too much or too little management support from USAID? Was there adequate monitoring of technical performance and of financial status?

III. PROJECT ACHIEVEMENTS AND LESSONS LEARNED

General

What are the Project's major achievements? What contributions have been made to state-of-the-art in the field of development communications? Have there been any methodological breakthroughs? What are considered to be the major strengths and weaknesses of the Project?

What new areas has the Project worked in? (e.g., health care financing, urban health) How have these new areas challenged health communication? or How has the communication methodology been adapted to these new areas?

What new groups did the Project work with (e.g., Vector Biology Control Project)? How well did these collaborations work? What did the project learn from these collaborations?

How well did the Project market its product (the methodology)? its results? What means have they used to disseminate information?

Behavior Change

Overall, what has been learned about behavior change? The following may be considered:

-How has the Project advanced our understanding of effective behavior change strategies? What models of behavior change have been explored and which suggest fruitful future inquiry?

-What has the Project learned about the hard-to-reach? What has the Project learned about prevention behaviors relative to treatment behaviors?

-What has the Project learned about "mixing" of strategies (i.e., print and mass media and, especially face-to-face communications) to promote and strengthen behavior change among community members and health workers?

-What are the major findings from the Applied Research component of the Project regarding behavior change and maintenance of changed behaviors? How has the Project modified research to measure individual behavior change? How has the Project strengthened program strategies to maintain behavior change?

Institutionalization and Sustainability

Overall, what has been learned regarding institutionalization and sustainability? The following may be considered when answering this question.

-Were Project goals related to institutionalization and sustainability realistic and appropriate? Overall, was the Project successful in meeting those goals?

-What strategies/approaches has the Project used to encourage institutionalization and/or sustainability of the communication methodology? What are the advantages and disadvantages of each? Is the goal of institutionalizing the "communication methodology" realistic, affordable, sustainable?

-Where have project efforts in this area been most and least successful? What has been learned in all of these areas that has relevance for the future?

-Taking into consideration the capabilities and infrastructure of the countries worked in, which of the Project achievements are likely to be sustained after the Project is finished? Why?

-To what extent did the Project target its institutionalization goals beyond the public sector to the private sector and to the community itself? How successful were these efforts and what are the main factors in such successes?

-What data were collected to help understand the cost-effectiveness of various communication interventions/approaches? Can the cost/benefit ratio of the Project's programs/activities be measured? Can one determine whether one mix of interventions is more cost-effective than another? To what extent were costs considered as a factor in institutionalization and sustainability and were country programs/activities designed with long-term resource availability in mind? What lessons are there for future USAID initiatives?

-What was the role of evaluation in the Project, particularly in terms of sustainability and institutionalization? To what extent was replicability considered in the development of communications methodologies and interventions? Is there evaluation data to support or reject strategies based on replicability in the field?

-How has the Project utilized training as a means to achieve behavior change and institutionalization objectives? Are there key aspects of their training approach that can serve as models for other projects and programs?

Annex D

Issue Papers and Papers Published in Scientific Journals

ISSUE REPORTS

"Sustaining Immunization Coverage: What Can Communication Do?" by Mark Rasmuson, October 14, 1990.

"Results & Realities: A Decade of Experience in Communication for Child Survival" by Renata Seidel, January,, 1992.

"Nothing to Sneeze At: Integrating Research into the Honduras ARI Communication Program," by John Elder, Patricio Barriga, Judith Graeff, Julia Rosenbaum, and Peter Boddy.

"Communication for Child Survival: Evaluation of HEALTHCOM Projects in Ten Countries," by Robert Hornik, Eduardo Contreras-Budge, Judith McDivitt, Jeffrey McDowell, P. Stanley Yoder, Susan Zimicki, and Mark Rasmuson, January 1991.

"Communication for Health and Behavior Change: A Developing Country Perspective," by Judith Graeff, John Elder, and Bette Booth (published in book form by Jossey-Bass, Inc., 1993).

"Developing a Marketing Function for Health Care Facilities: A Practical Guide" by Dana M. Faulkner, February, 1995.

"The Measurement of Patient Satisfaction in Health Care Services: A Practical Guide, by Louise F. Kemprecos, Dana M. Faulkner and Salah Hassan, PHD., April, 1995.

"Traditional Beliefs and Practices Related to Child Diarrhea and Sexually-Transmitted Diseases: Building a Cooperative Communication Strategy," (about the role of the traditional healer in health communication programs with particular emphasis on the situation in Mozambique), by HEALTHCOM consultant Edward Greene, Annemarie Jurg, Taju Tomas, Armando Dgedge, June 1994

"Fatayat Cost Study", by Joe Diederich and Will Shaw, April, 1995.

A comparison of the impact and costs of a Metro Manila measles campaign and a nationwide urban intervention, by Birch and Davis, (draft in review)

SCIENTIFIC JOURNAL ARTICLES

Elder, John, Peter Boddy, Patricio Barriga, Ana Lucila Aguilar, and Hector Espinal. "La Experiencia Hondureña en el Control de las Infecciones Respiratorias Agudas Infantiles." In *Boletín de la Oficina Sanitaria Panamericana* 110 no. 5 (1991): 390-401. (English translation available.)

Elder, John, Terry Louis, Omaj Sutisnaputra, Neni Surani Sulaeiman, Lisa Ware, Willard Shaw, Carl de Moor, and Judy Graeff. "The Use of Diarrhoeal Management Counselling Cards for Community Health Volunteer Training in Indonesia: the HEALTHCOM Project." In *Journal of Tropical Medicine and Hygiene* 95 (1992): 301-308.

Elder, John, Maria Eugenia Pradesaba, Olga Polanco Pineda, Kjell I. Enge, Judith Graeff, Diane Urban, and José Romero. "A Behavior Analysis of the Promotion of Oral Rehydration Therapy in Guatemala." In *International Quarterly of Community Health Education* 9 no. 2 (1988-89): 139-150.

Elder, John, Thomas Reis, Satoto, and Rahardjo Suwandi. "HEALTHCOM/Indonesia: The Use of Radio Spots to Improve Performance and Motivation of Kader." In *Hygie* 11 no. 4 (December 1992): 21-25.

Green, Edward C., Annenmarie Jurg, and Armando Dgedge. "Sexually Transmitted Diseases, AIDS and Traditional Healers in Mozambique." In *Medical Anthropology* 15 (1993): 261-281.

Haider, Syed J., Mohammad Al-Hamly, Adel Barakat, John P. Elder, and Anne H. Roberts. "Interpersonal Education by Rural Yemeni Women for Promoting Child Survival and Maternal Health." Accepted for publication by the *International Quarterly of Community Health Education.*

Helitzer-Allen, Deborah L., and Carl Kendall. "Explaining Differences between Qualitative and Quantitative Data: A Study of Chemoprophylaxis During Pregnancy." In *Health Education Quarterly* 19, no. 1 (Spring 1992): 41-54.

Helitzer-Allen, Deborah L., Carl Kendall, and Jack J. Wirima. "The Role of Ethnographic Research in Malaria Control: An Example from Malawi." In *Research in the Sociology of Health Care*, Vol 10 (1993): 269-286.

Helitzer-Allen, Deborah L., Deborah A. McFarland, Jack J. Wirima, and Allen P. Macheso. "Malaria Chemoprophylaxis Compliance in Pregnant Women: A Cost-Effectiveness Analysis of Alternative Interventions." In *Social Science and Medicine* 36, no. 4 (1993): 403-407.

McDivitt, Judith, Robert Hornik, and Ayman Abulaban. "The Impact of the HEALTHCOM Mass Media Campaign on Timely Initiation of Breastfeeding in Jordan." Accepted for publication by *Studies in Family Planning.*

Rasmuson, Mark, Holly Fluty, and Robert Clay. "HEALTHCOM: Lessons from 14 Years in Health Communication." In *Development Communication Report* 77, no. 2 (1992): 1-5.

Reis, Tom, John Elder, Satoto, B.A. Kodyat, and Anne Palmer. "An Examination of the Performance and Motivation of Indonesian Village Health Volunteers." In *International Quarterly of Community Health Education* 11 no. 1 (1990-91): 19-27.

Snyder, Leslie B. "Channel Effectiveness Over Time and Knowledge and Behavior Gaps." In *Journalism Quarterly* 67 no. 4 (Winter 1990): 875-886.

Snyder, Leslie B. "Modeling Dynamic Communication Processes with Event History Analysis." In *Communication Research* 18, no. 4 (August 1991): 464-486.

Taplin, David, and Maureen Vicaria. "Fighting Cholera with Solar Energy." In *North South Magazine* (March 1993).

Touchette, P., Elder J., and Naigel M., "How Much Oral Rehydration Solution is actually Administered During Home-based Therapy?" In *Journal of Tropical Medicine and Hygiene.* 1990-93; 28-34.

Yoder, P. Stanley, and Robert Hornik. "Perceptions of Severity of Diarrhea and Treatment Choice: A Comparative Study of HEALTHCOM Sites." Accepted for publication by the *Journal of Tropical Medicine and Hygiene.*

Yoder, P. Stanley. "Cultural Conceptions of Illness and the Measurement of Changes in Morbidity." Chapter 4 in *The Health Transition: Methods and Measures*, edited by John Cleland and Allan G. Hill, 43-59. Canberra: Australian National University Printing Service, 1991.

Yoder, P. Stanley, and Bihini Yanka. "Etude Ethnomédicale des Maladies Diarrhéiques à Lubumbashi, Zaire." In *Santé Culture Health* 8 (1): 77-107.

Yoder, P. Stanley, Judith A. McDivitt, and Robert Hornik, "Knowledge of Oral Rehydration and Response to Diarrhea: A Comparison among HEALTHCOM Sites," in *International Quarterly of Community Health Education*, Vol. 13(3) (1992-93:201-217).

Annex E

Description of Healthcom II Materials

Description of Healthcom II Materials

Manuals/Published Books

Communication for Health and Behavior Change: A Developing Country Perspective

This book summarizes for the academic community many of the lessons learned through Healthcom projects. It first discusses the theoretical basis for behavioral analyses, and how this approach fits with other theories of health behavior. It addresses each of the steps in the model, and also discusses the lessons learned from a research perspective. The publication of the extensive information gained through Healthcom in a book ensures that it has the potential of reaching a larger audience than the 1,500 on the mailing list, or others familiar with USAID projects. It also helps enhance the validity of the behavioral approach by summarizing results from many of the research projects conducted under Healthcom. The choice to have the book published by a major publisher rather than as a Healthcom publication, was to make it more likely that schools of public health and communication might use the book in their courses.

A Tool Box for Building Health Communication Capacity

The Tool Box is an adapted and expanded version of the book described above. Its principal use is as a manual designed to help managers of health communication programs to improve their unit's organization, and to strengthen communication skills and ability to apply the communication methodology. It was completed during the last month of the contract and eight hundred copies were distributed to a list of health communication professionals in developing countries and professionals working in USAID child survival projects in the US.

There are three sections in the Tool Box. The first section helps managers assess the environment in which they work (an external analysis) and their unit's organization (internal analysis), and then create an organizational development plan. It then illustrates in detail the steps needed to define a health communication strategy and develop the communication plan.

The methodology section of the Tool Box is presented in the form of 25 questions (addressed in individual chapters) and answers corresponding to the Healthcom methodology. (1) Assess (questions 1-12), 2) Plan (questions 13-17), 3) Draft, Pretest, Produce (18-21), 4) Deliver (22-23), 5) Monitor and Evaluate (24-25). The Tool Box is written in the style of a training manual, with the expected skills and knowledge to be gained from each chapter, case study examples and exercises, and worksheets to be completed.

The third section of the Tool Box includes a sample procedures manual for a Health Education Unit, and a Seminar Guide for a one-day meeting to formulate a national policy for health communication and education.

Due to the publication of the manual at the end of the project, it was never pretested nor sent out for review prior to its publication. Its utility would be enhanced if it were pretested, since on reading it for this evaluation, there was some difficulty in understanding its format, thus making

it hard to comprehend some of the context. While the inclusion of computer discs of the manual's content is innovative, no reference is made to the discs, nor how they could be used.

Because the Tool Box contains a considerable amount of valuable information, it would be useful to pretest, revise, and translate it through the BASICS project. This could be done in the context of a national program.

Another innovative series of modules that is quite similar to the Tool Box was developed in Spanish with the Division of Health Education in the Ministry of Health in Honduras. It differs from the Tool Box by including a set of nine separate modules, with a different format (including comical drawings and figures) with less issues addressed than the Tool Box.

Getting it in Focus: A Learner's Kit for Focus Group Research

This kit was designed to help focus group moderators plan and conduct focus groups. It includes a 34-minute Training Video for Moderating Focus Groups, A Handbook for Excellence in Focus Group Research, and A Skill Building Guide for Making Focus Groups Work. The video shows how a new moderator is supervised to help improve her skills in moderating focus groups. The guide gives step-by-step details for the moderator to follow in planning and running a focus group. It also provides helpful information that can be used along with the video in a training workshop for new moderators. The guide also includes a suggested workshop design to help trainers develop the training workshop. The Handbook is a more technical document for experienced focus group researchers and provides background information useful in the design of focus groups.

These materials, also produced in French, Spanish, and Bahasa Indonesia, provide excellent guidance for focus group research, but also could have other important uses. The video and the associated guide could be useful for improving supervision techniques for health workers, and for training of health workers or volunteers in running mothers' support groups or mothers' clubs sessions. The techniques described (such as the importance of rapport building and how to do so, the types of questions to ask to keep the group discussing an issue, and the questions to avoid [such as serial questioning or asking "why"]) are useful for many different types of groups, not only focus groups.

Notes from the Field: Communication for Child Survival

By including field experiences with research, strategies used for behavior change, design and testing of materials, principals and tools for training, and new policies, this volume can be used to help others plan and conduct health communication activities in their own countries. The results of survey research on diarrhea (in the Philippines), ethnomedical qualitative studies on diarrhea (in Nigeria and Zaire), issues in questionnaire design for a pilot study of ARI (in Honduras), and training in focus groups (Jordan), illustrate some of the issues involved in conducting research on health communication topics.

The behavior change strategies used in a breastfeeding promotion program in Jordan, an ORS program in the Philippines, and a Vitamin A capsule program in Indonesia provide detailed accounts of how these communication activities were conducted.

The design and testing of the materials section gives examples of design and pre-testing of monitoring forms (Malawi), counseling cards (Indonesia), flip-charts (Ecuador), and radio spots (Swaziland). The training section discusses field experiences in training health workers in Nigeria, Indonesia, Papua New Guinea, and Ecuador.

Many of the articles illustrate the difficulties involved in developing health communication programs, and would be excellent background for others to read prior to developing new activities in the field.

Direct mail (e.g., to kaders in Indonesia)

A particularly successful and innovative means of disseminating information within a country project was the use of direct mail for training materials in Indonesia. This was found to be more effective than distributing information to the health centers, and expecting them to distribute materials to the volunteer kaders.

Issue Papers

A list of the issue papers produced by Healthcom II is provided in Annex D. Some of the issue papers that were particularly useful summarized many of the results of Healthcom I and II.

Unlocking Health Worker Potential: Some Creative Strategies from the Field

As stated in this issue paper, one of the lessons learned through Healthcom activities was "the point at which mothers and children come into contact with the health care system through the health workers is crucial to defining the quality and effectiveness of the service provided" (p. 5). While health workers are trained in the technical aspects of disease prevention and management, they are rarely taught "how to listen to mothers' points of view or communicate effectively with them." This manual is an excellent resource to help improve health workers' abilities to communicate well with mothers. It provides useful ideas for supervisors to use in helping improve health workers' and volunteers' skills in this area. It is written from the focus of understanding the constraints that health workers face, and not from one that is critical.

All of these products were quite innovative and should prove to be very useful. However, since the first three were produced at the end of the project, there was little time for marketing the products nor for evaluating their effectiveness. It would therefore be useful for BASICS to follow up on these activities. (See Recommendations Section.)

57

Developing a Marketing Function for Health Care Facilities, and
The Measurement of Patient Satisfaction in Health Care Services: A Practical Guide

These two papers from the Egypt Cost Recovery Program provide excellent guidance on how to develop a marketing program for hospitals that want to expand services in order to obtain fee-for--service. They were completed near the project's end and mailed out with the Tool Boxes. These papers should be made more widely available, and distributed by BASICS.

Results and Realities: A Decade of Experience in Communication for Child Survival

This issue paper summarizes the communication methods used and the results of the major long-term projects conducted in Healthcom I. It is a user-friendly report that takes the extensive results of the evaluations conducted by Annenberg and presents them for non-researchers. By showing some of the types of media used (in color), it helps to clearly illustrate how the projects were implemented. However, as discussed elsewhere in this evaluation, this report primarily summarizes the positive results of selected projects, without discussing projects that were not successful.

Nothing to Sneeze at: Integrating Research into the Honduran ARI Communication Program

This paper summarizes the program efforts of an ARI program and gives the results of the qualitative and quantitative research conducted as part of the program. It should be very useful to others who develop ARI prevention programs.

Videos/Slides and Associated Guides

Will She Return?

This is an excellent training video produced in Burkina Faso to help improve health worker practices. It focuses on interpersonal communication skills, and illustrates the constraints mothers face in obtaining immunizations for their infants in order to sensitize health workers and improve their interactions with mothers.

Developing a Social Marketing Strategy for Communication Programmes

This slide show and curriculum guide can be used for a workshop on social marketing. It uses the Philippines Immunization Program as an example, and provides all the slides, worksheets, certificates, and background material needed to conduct a ten-hour social marketing workshop for 20 people.

Things Have Changed

This 20-minute video, shot in Tijuana, Mexico, illustrates how health workers can promote changes in health behavior to improve children's health. It emphasizes the need for health workers to learn about the people that they work with to understand their behaviors. It also illustrates that only harmful behaviors should be changed, and that health workers need to understand the constraints that

families face in making the proposed behavior changes. The guide that accompanies the video helps the trainer promote discussions about the ideas presented. This video was produced in Spanish, French, and English.

Curricula

Appropriate Research Technology

In addition to the workshop materials that can serve as training curricula, this curricula is designed for a workshop on research methods for planning, evaluating, and improving child survival programs. It is oriented to academic institutions, and can be adapted for use in regular courses, such as in schools of public health.

Modular course for Communication Planning of Community Nutrition Programs, and Modular Course for Communication and Transfer of Knowledge

This course was developed with Healthcom assistance for use in diploma and masters level programs in Schools of Public Health in Indonesia. A copy could not be obtained to review for this evaluation.

Scientific Publications

Many of the scientific publications produced in Healthcom II were based on the results of research and evaluation activities initiated in Healthcom I. Much of the research compares results from several of the evaluations to illustrate patterns across different countries.

Training Modules

Many of the above materials serve as training modules. In addition, there were several other training modules developed specifically for WHO, including a health communication module with slides for WHO/EPI for regional training of EPI managers and three modules for WHO/EPI training of health workers. We were only able to obtain one to review.

A Guide to Using Radio Spots in National CDD Programmes

This guide, developed in collaboration with WHO/CDD, follows the Healthcom methodology to help managers develop radio spots for a CDD program. Rather than being used as a training course, it helps the managers and their staffs to learn while performing the function.

Annex F

List of Healthcom Materials for Distribution by BASICS

SELECTED HEALTHCOM PROJECT DOCUMENTS AND AUDIOVISUAL MATERIALS

Please check the documents you wish to order. Be sure to indicate language if an item is listed as available in more than one language.

Prepayment is required on all orders from developed countries. Please make checks in U.S. dollars payable to the Academy for Educational Development.

Single copies of all "special publications" are available at no charge to people in developing countries. Requests for multiple copies will be considered with a letter explaining how they will be used. (Reimbursement for mailing costs may be requested.) Up to ten different publications listed at a cost under $10 each are available at no cost to people in developing countries.

Please note our return policy: 75% of purchase is refunded if publications are returned in good condition. (The balance is retained to cover the cost of postage and handling.)

Special Publications

$3 ____ Andreasen, Alan. *Social Marketing: Its Potential Contribution in the Public Sector.* HEALTHCOM Project special report series. Washington, DC: Academy for Educational Development, September 1988.

$10 ____ Caluñero-Verzosa, Cecilia, Marietta C. Bernaja, Eleanora M. De Guzman, José Rafael S. Hernandez, Carmencita N. Reodica, and Mario M. Taguiwalo. *Managing a Communication Program on Immunization: A Decision-making Guide.* Washington, DC: prepared jointly by the HEALTHCOM Project and the Department of Health, Republic of the Philippines; December 1989.

$10 ____ Debus, Mary. *A Handbook for Excellence in Focus Group Research.* HEALTHCOM Project special report series. Washington, DC: Porter/Novelli, 1988.

$5 ____ HEALTHCOM Project. *Behavioral Research in Child Survival: Studies from the HEALTHCOM Project.* Washington, DC: Academy for Educational Development, April 1992. (A number of the individual chapters are also available separately under "Published Articles" listed below.)

$3 ____ Rasmuson, Mark, ed. *Institutionalizing a Methodology for Public Health Communication: A Midproject Report.* HEALTHCOM Project special report series. Washington, DC: Academy for Educational Development, September 1988.

$10 ____ Rasmuson, Mark R., Renata E. Seidel, William A. Smith, and Elizabeth Mills Booth. *Communication for Child Survival.* Washington, DC: Academy for Educational Development, June 1988. (Available in English, French, Spanish, and Bahasa Indonesia.)

$15 ____ Seidel, Renata, ed. *Notes from the Field in Communication for Child Survival.* Washington, DC: Academy for Educational Development, April 1993.

$10 ____ Seidel, Renata. *Results and Realities: A Decade of Experience in Communication for Child Survival.* Washington, DC: Academy for Educational Development, January 1992.

Also available: Graeff, Judith A., John P. Elder, and Elizabeth Mills Booth. *Communication for Health and Behavior Change.* San Francisco, CA: Jossey-Bass Publishers, 1993. This book must be ordered directly from the publishers at $23.95 per copy. Bulk rates available. Contact the publisher at 350 Sansome Street, San Francisco, CA 94104. (Fax 1-800-605-BOOK) A complimentary copy is available from the Academy to professionals in developing countries.

Evaluation Documents and Final Reports

$.50 ____ Martorell, Reynaldo. *Institutionalization of Health Communication Methodology in Honduras.* Menlo Park, CA: Applied Communication Technology, January 1989.

$.50 ____ McDivitt, Judith, and Jeanne Moulton. *Institutionalization of Health Communication Methodology in The Gambia.* Menlo Park, CA: Applied Communication Technology, July 1988.

Published Articles

N/C ____ Clift, Elayne. "Social Marketing and Communication: Changing Health Behavior in the Third World." In *American Journal of Health Promotion* 3, no. 4 (Spring 1989): 17-24.

N/C ____ Rasmuson, Mark, Renata Seidel, and Haddy Gabbidon. "Dietary Management of Diarrhea: The Gambian Experience." In *Journal of Nutrition Education* 22, no. 1 (February 1990): 15-23.

N/C ____ Shafritz, Louise E., and Anne Roberts. "The Value of Focus-Group Research in Targeting Communication Strategies: An Immunization Case Study." In *Health Transition Review* 4, no. 1 (April 1994): 81-85.

Working Papers and Reports

$.50 ____ Douglass, Edward. "Pretesting Health Education Materials." Washington, DC: Academy for Educational Development, 1989. (Available in English, French, and Spanish.)

$.50 ____ Ferencic, Nina. "Guidelines for Carrying out In-depth Interviews about Health in Ecuador." Philadelphia: CIHDC, Annenberg School for Communication, University of Pennsylvania, 1988.

$.50 ____ Gould, Robert J. "Training Ecuadoran Health Communication Professionals in the Use of Qualitative Research Techniques." Washington, DC: Porter/Novelli, 1988.

$.50 ____ Heitzer-Allen, Deborah, Lawrence Kapachika, Stacey Lisset, Julia King, and Trisha Droney. "Pretesting Materials in Malawi: An Example of Improvement in Communications." Washington, DC: Academy for Educational Development, 1989. (Available in English and Spanish.)

62

$.50 ____ Rasmuson, Mark. "Sustaining Immunization Coverage: What Can Communication Do?" Discussion paper prepared for the 1990 Global Advisory Group Meeting of the WHO Expanded Programme on Immunization, Cairo, October 1990.

$3.00 ____ Vigaro, Oscar. *Communication, Community, and Health: Final Report of the Honduras Water and Sanitation Communication Project*. Tegucigalpa: HEALTHCOM Project, December 1985.

Audiovisual Materials

$10 ____ HEALTHCOM and Hr Productions. *Health Communication: Partnerships for Survival*. A 30-minute videotape. Available in English, French, and Spanish. Summary 9-minute version also available in English, French, Spanish, and Arabic. 1989.

$10 ____ HEALTHCOM/PNG and FirstTake Productions, Port Moresby. *Making Things Clear*. A 13-minute videotape for training health workers in interpersonal communication skills. Produced in English and Tok Pisin. 1989.

Note: For documents and videos available in different languages, please specify the language.

When ordering videos, please specify the following:

Format: NTSC/PAL/SECAM

Tape: VHS/BETA

April, 1995